

NURSING FACILITY TRANSITION EXCEPTION REQUEST FIELD DEFINITIONS

A completed Nursing Facility Transition Exception Request form must be sent to MDCH when requesting transition services for an individual who:

- Has been in the nursing facility for less than four months (and the waiver agent does not have a corresponding NFT participant who has been in the facility over six months),
- Has been in the nursing facility for greater than four months but less than six months (and the waiver agent does not have a corresponding NFT participant who has been in the facility over six months),
- Has one-time transition costs that are expected to exceed \$3,000.00,
- Is not in a facility, but is at imminent risk of nursing facility placement (diversion),
- The LTCC (Long Term Care Connection) cannot meet with the NF resident to do the initial transition interview and the Waiver Agent or Center for Independent Living wishes to complete the interview (attach LTCC approval for such a request)
- Needs coordination/support services beyond 6 months post-transition.
- Other – specify

The following is an explanation of all fields in the Nursing Facility Transition Exception Request form. The waiver agent must complete all fields for each NFT exception form submitted.

<i>NFT Exception Request Field</i>	<i>DESCRIPTION</i>
<u>Transition Agent Information:</u>	
Agency	The name of the agency facilitating the NFT.
Today's Date	The date the Transition Exception Notice was completed.
Contact's Name	The name of the person MDCH should contact about this transition.
Contact's Phone	The phone number of the person MDCH should contact about this transition.
Contact's Email	The email address of the person MDCH should contact about this transition.
<u>Transitionee Information:</u>	
Last Name	The last name of the NFT participant.
First Name	The first name of the NFT participant.
Date of Birth	The NFT participant's date of birth.
Medicaid I.D. #	The NFT participant's ten-digit Medicaid Recipient ID number.
Social Security #	The NFT participant's Social Security Number.
Admission Date	The date the individual was admitted to the nursing facility.
Prior admission?	The date of admission to a hospital or another nursing facility if stay was immediately preceding the current nursing facility stay.
<u>Type of Exception Requested</u>	
Check the box most appropriate to the type of exception requested for this NFT participant.	
Comments	Rationale for requesting an exception. Include information about the individual's condition and support system, barriers to transitioning, and services the individual will need post-transition if request is for less than 4 or 6 months, exception to the wait list, or a diversion. If request is to spend more than \$3000 describe what expenditures you wish to make.

Nursing Facility Transition Program
400 South Pine Street, P.O. Box 30479
Lansing, MI 48909-7979
(517) 373-9532

NURSING FACILITY TRANSITION EXCEPTION REQUEST

Transition Agent Information	
Agency (Name & city):	Today's Date:
Contact's Name:	
Contact's Phone:	Contact's Email:

Transitionee Information	
Last Name:	First Name:
Date of Birth:	Medicaid I.D. #:
Social Security #:	
Date of admission to nursing facility:	
Date of hospital or other NF admission if immediately preceding current NF stay:	

Type of Exception Requested and Rationale for Request	
<input type="checkbox"/> Less than 4 months in nursing facility prior to transition <input type="checkbox"/> Greater than 4 months, but less than 6 months in nursing facility prior to transition <input type="checkbox"/> One-time transition costs, including coordination and support, exceed \$3,000 <input type="checkbox"/> Diversion of individual with impending nursing facility admission <input type="checkbox"/> Long Term Care Connection (LTCC) unable to complete transition interview, Waiver Agent or Center for Independent Living wishes to do so (attach LTCC approval for request). <input type="checkbox"/> Move up on wait list. <input type="checkbox"/> Other (describe)	
<p>Rationale for exception request. For exception requests for less than 4 or 6 months, to move up on the wait list, or for a diversion include: 1) individual's condition and support system, 2) transition barriers you will address, and 3) services needed post-transition. For requests to spend more than \$3000, describe expenditures you wish to make. (add additional pages if needed)</p>	
<p>AUTHORITY: None COMPLETION: Is voluntary, but this information is required for transition services.</p>	<p>The Department of Community Health is an equal opportunity employer, services, and programs provider.</p>